

Complaint No. _____

**COMPLAINT FORM
KENTUCKY BOARD OF CHIROPRACTIC EXAMINERS**

Person Filing Complaint

Name _____

Address _____ City _____ State _____ Zip _____

Day Telephone (____) _____ Night Telephone (____) _____

Patient's Date of Birth ____/____/____

Patient Information (if different from above)

Name _____

Address _____ City _____ State _____ Zip _____

Relation _____

Name of Chiropractor who performed services

Name _____

Address _____ City _____ State _____ Zip _____

Telephone (____) _____

Names and phone numbers of persons who may provide additional information.

Brief description of offense, include date, time and location

Continue on next page

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Signature _____ Date _____
(patient or guardian)

Send to:
Kentucky Board of Chiropractic Examiners
P.O. Box 183
Glasgow, KY 42142-0183